Managed Care MC+

What does this appropriation support?

It provides funding for capitation payments to managed care health plans on behalf of MC+ eligibles enrolled in managed care.

The Division of Medical Services (DMS) operates an HMO-style managed care program, MC+ Managed Care. Health plans contract with the state and are paid a monthly capitation payment for providing services for each enrollee. Participation in MC+ Managed Care is mandatory for certain Medicaid eligibility groups within the regions in operation. The mandatory groups are: Medical Assistance for Families-Adults and Children, Medicaid for Children, Refugees, Medicaid for Pregnant Women, Children in State Care and Custody, and 1115 Waiver Children (MC+ for Kids) and Adults. Those recipients who receive Supplemental Security Income (SSI), meet the SSI medical disability definition or get adoption subsidy benefits may stay in MC+ Managed Care or may choose to receive services on a fee-for-service basis. The MC+ Managed Care program is currently operating in the Eastern Region since September 1, 1995, in the Central Region since March 1, 1996, and in the Western Region since January 1, 1997.

What is its statutory authority?

State statute: RSMo. 208.166; Federal law: Social Security Act Sections 1115, 1902(a)(4), 1903(m), 1915(b), 1932; Federal regulations: 42 CFR 438

Is this a federally mandated program?

Managed care covers most services available to fee for service eligibles. As such, both mandatory and non-mandatory services are included. Services not included in managed care are available fee for service.

Are there federal matching requirements?

States can earn the federal medical assistance percentage (FMAP) on Medicaid program expenditures. The Social Security Act requires the Secretary of Health and Human Services to calculate and publish the actual FMAP each year. The FMAP is calculated using economic indicators from states and the nation as a whole. Generally, Missouri's FMAP for FY-2007 is a blended 61.68% federal match. The state matching requirement is 38.32%.

What are the expenditures?

	FY 2003 Actual	FY 2004 Actual	FY 2005 Actual	FY 2006 Planned
GR	$87,954,600	$157,811,349	$186,524,842	$162,418,851
FEDERAL	$385,254,847	$464,941,521	$502,605,502	$554,297,358
OTHER	$151,815,336	$127,899,647	$128,770,210	$173,552,840
TOTAL	$625,024,783	$750,652,517	$817,900,554	$890,269,049

What are the sources of other funds?

Federal Reimbursement Allowance Fund, Health Initiatives Fund, Healthy Families Trust Fund-Health Care Account and Medicaid Managed Care Organization Reimbursement Allowance Fund (new in FY-2006)

Who is eligible?

Participation in MC+ managed care for those areas of the state where it is available is mandatory for these eligibility categories:

- Medical Assistance for Families
- Medicaid for Children
- Refugees
- Medicaid for Pregnant Women
- Children in State Care and Custody
- 1115 Waiver Adults and Children

How many people have been served?

Managed Care Enrollees (Excludes 1115 Waiver Eligibles)		
FY	Actual	Projected
2003	377,605	
2004	381,937	
2005	375,250	
2006		382,633
2007		399,852
2008		417,845

Efficiency and Effectiveness Measures: